Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4985AGZ	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACEY RESIDENTIAL CARE	**5329 STACY AVENUE LAS VEGAS, NV 89108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on June 26, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. There were no complaints investigated. On 6/26/09 an annual state licensure survey was attempted at the facility. At the time of the survey the property appeared vacant. The gate surrounding the property was locked with a chain and pad lock. There was also a black lock box attached to the gate. The surveyor was unable to gain entry into the property. Interview with the owner, confirmed that the property is vacant and the facility has never had any residents living at the facility. However, the facility still has a current Residential Facility for Group Care license. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE